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ABSTRACT

Intended for use in Florida training programs for caregivers of infants and toddlers with disabilities, this guide presents an overview of the Model of Interdisciplinary Training for Children with Handicaps (MITCH); offers a user's guide to the series; and provides specific information for presenting Module 13, which focuses on interventions for children at risk due to substance exposure. After the introduction to the MITCH program as a whole, the user's guide provides information on the instructor's role, the 3-hour training session, the use of videotapes and audiotapes, and follow-up activities. For this module, goals and objectives focus on providing participants with an understanding of cocaine, effects of coaine on prenatal development, effects of cocaine on the mother, possible effects of cocaine on child development, identification of infant states of behavior, what is known (and not known) about the carryover effects of cocaine, the role of the caregiver, promoting a healthy environment, and the importance of not labeling a child as a "cocaine baby." For each hour of training, a script, suggested activities, and relevant handouts are provided. Attached are lists of recommended resources and references, reproducible forms and handouts, and forms for the 6-week follow up. (DB)

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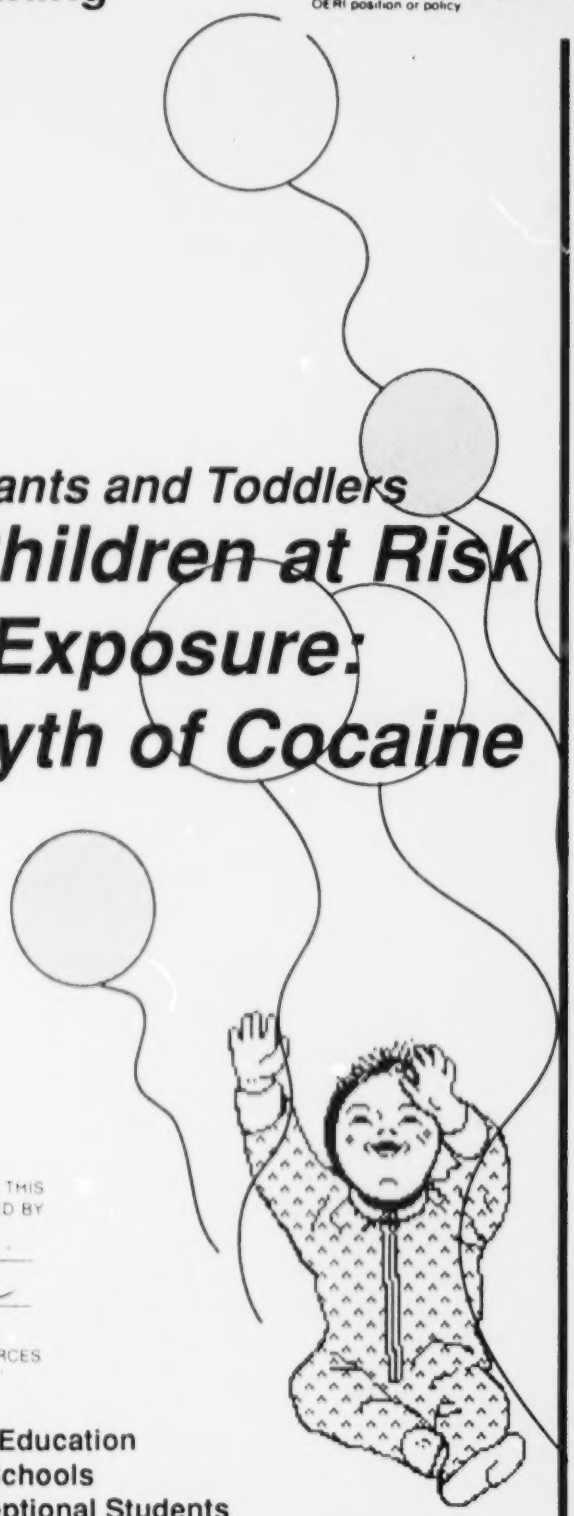
MITCH Module 13

Model of Interdisciplinary Training for Children with Handicaps



A Series for Caregivers of Infants and Toddlers

Interventions for Children at Risk Due to Substance Exposure: Dealing with the Myth of Cocaine

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MITCH Module 13

Model of Interdisciplinary Training for Children with Handicaps

A Series for Caregivers of Infants and Toddlers

Interventions for Children at Risk Due to Substance Exposure: Dealing with the Myth of Cocaine

Florida Department of Education
Division of Public Schools
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1992

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MITCH Module 13

Model of Interdisciplinary Training for Children with Handicaps

A Series for Caregivers of Infants and Toddlers

Interventions for Children at Risk Due to Substance Exposure: Dealing with the Myth of Cocaine

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Introduction

Information in the Introduction should be reviewed by each instructor or user of this material. The User's Guide to Series begins on page 5. Information relating to this module begins on page 11.

PROJECT MITCH OVERVIEW

The purpose of the Project MITCH (Model of Interdisciplinary Training for Children with Handicaps) training series is to assist local school districts in Florida in providing interdisciplinary training and resources to parents, non-degreed daycare workers, and healthcare providers who work with special needs infants and toddlers ages 0-5, with emphasis on ages 0-2.

This series was funded by a grant to the Florida Diagnostic and Learning Resources System/South (FDLRS/South), on behalf of the FDLRS Network, from the Florida Department of Education, Bureau of Education for Exceptional Students (BEES).

In 1987, the Florida Legislature designated $100,000.00 of the total appropriation for the FDLRS Network to "expand services to infants and preschool children." The application submitted by Dade County on behalf of the FDLRS/South Associate Center serving Dade and Monroe Counties was selected for funding and was initiated on May 25, 1988. FDLRS/South collaborated with FDLRS/Mailman at the University of Miami and FDLRS/Gateway, serving Hamilton, Columbia, Lafayette, Madison and Suwannee counties, to complete the work under the grant. Outcomes of the project include:

- assessment of the status of training and resources for the designated population
- design of a collaborative implementation and training model to include development of competencies, replicable training modules which enhance or expand the HRS eight-hour special needs child care module, an adapted training plan for daycare providers, recommendations for curricula to be used in daycare and preschool programs, and recommendations for provision of consultation to parents
- validation of the training modules in Dade, Monroe, and counties served by FDLRS/Gateway
- provision of training for potential instructors and other interested personnel in the 18 FDLRS Associate Center service regions.

Topics for the original eleven training modules, as well as information which provided the basis for the competencies, policy framework, and other products of Project MITCH, were obtained from a literature search, interviews, and letters of inquiry and needs assessments sent to over 600 persons throughout the State of Florida. The modules were written by several authors from various disciplines, including early childhood education, exceptional student education, nursing, occupational and physical therapy, speech and language, nutrition, and social work. Each module was read by several critical readers and was piloted in both north and south Florida at least three times before final rewriting took place.

The training series emphasizes developmentally appropriate practice and normal development as the means for working with youngsters who have special needs. The thirteen three-hour modules that currently make up the series have relevance for caregivers of normally developing children as well as caregivers who may be working with children who are handicapped, experiencing delays, or who may be at risk. Although several of the modules specifically address normal and abnormal development from birth to 36 months of age, the material is also meaningful to caregivers of preschoolers who are chronologically older but who are functioning developmentally within the birth to three year range.

MITCH MODULES

Thirteen MITCH training modules have been developed.

(1) *Intellectual Development: What You Can Do to Help*

(2) *Speech and Language Development: What You Can Do to Help*

(3) *The Child Who Seems Different: Meeting Special Needs*

(4) *Family Functioning: The Impact of a Child with Special Needs*

(5) *Listening and Sensory Integration: What to Do Before Speech and Language Develop*

(6) *The Caregiving Environment: Planning an Effective Program*

(7) *Behavior Management: Preventing and Dealing with Problem Behavior*

(8) *Health Care: Infection Control, Medication Administration, and Seizure Management*

(9) *Motor Development: What You Need to Know*

(10) *Nutrition and Feeding Practices: What You Need to Know*

(11) *Working Together: Communication Skills for Parents, Caregivers, and Other Professionals.*

(12) *Visual Impairments: What You Need to Know*

(13) *Interventions for Children At Risk Due to Substance Exposure: Dealing with the Myth of Cocaine*

Each of the three-hour modules can be used independently. Although the modules are numbered sequentially, they may be presented in any order since no module provides prerequisite material for another. Each module contains a script for the instructor, activities, references, resource list, and reproducible handouts/overheads. In some cases, a videotape and/or an audiotape and other materials are available to supplement the written material.

MITCH BOOKLETS

Three booklets have also been produced through MITCH. These may be used with modules as indicated or may be used independently. The booklets are listed below:

- *A Simple Introduction to Physical and Health Impairments*, to be used with Module 3
- *Welcome to the World: An Overview of Your Growing Child*, to be used with Modules 1, 2, 3, 6, and 7
- *Curricula for Use with High Risk and Handicapped Infants and Toddlers*, for use as a supplement to the modules.

User's Guide to Series

INSTRUCTOR

Instructor Qualifications

Unless otherwise stated, the MITCH modules are designed to be presented by qualified and credentialed instructors in fields such as early childhood special education, early childhood education, special education, child development, psychology, home economics and nursing.

Role of Instructor

Although the modules do contain scripts, the instructor is encouraged to add to them with his own style, personality, anecdotes, information, handouts, references and resources. It is expected that the instructor will exercise judgement in tailoring the material to the needs, interests, and level of the participants. The best presentations will be those that are specifically designed for the participants by the instructor who best knows their needs.

The instructor may change the lecture/discussion and activity ratio depending upon the group's needs. If all modules are being scheduled for presentation within a relatively short period of time for the same group of participants, the instructor may choose among the activities in order to offer variety since several modules share similar types of activities. The instructor will need to plan adequate time in order to become familiar with the material and tailor it to the needs of each specific audience.

A successful presentation of the material is heavily reliant upon an enthusiastic style on the part of the instructor. Suggestions for achieving this include:

- allow for introductions of participants
- accept and acknowledge interaction from all
- paraphrase questions and responses from the participants loudly enough for all to hear
- create a comfortable atmosphere
- summarize the content of each session before closing.

The audience may include a broad range of persons, including those who knowingly work with very young children with special needs, to others who may have children under

their care who have special needs that are not yet recognized. The instructor should assist all caregivers in becoming more comfortable with:

- recognizing indicators that a child may be at risk or may have special needs
- working with that child
- getting additional support and assistance for such a child.

It will be important to emphasize that all children are more like one another than they are different. Keeping children in the most natural or normal environment is a major goal for caregivers.

Instructor Preparation and Follow-Through

Prior to presenting any of the thirteen three-hour modules, we recommend that each instructor:

- become entirely familiar with the content and format of presentation
- preview any videotape and/or audiotape
- set date for training
- arrange for a comfortable room in which to present the training
- advertise training in a timely fashion (see reproducible flier in Appendix A)
- arrange for the use of an audiocassette player, VHS videocassette recorder, overhead projector and screen, as needed
- photocopy all handouts and the List of Participants
- prepare overhead transparencies and/or other materials
- collect any additional materials not provided in this packet (see materials list).

After presenting any of the thirteen three-hour modules, the instructor should:

- photocopy the reminder letter for each participant regarding the return of the Six-Week Follow-Up Activity
- mail the reminder letters three to four weeks after presenting the training module
- collect, or have participants mail, the completed Six-Week Follow-Up Activity
- review completed Six-Week Follow-Up Activity for each participant
- photocopy Certificate of Completion
- complete Certificate of Completion

- deliver or mail Certificates of Completion to each participant who successfully completed the Six-Week Follow-Up Activity
- maintain a complete record of persons who have successfully completed the module, using the List of Participants.

Reproducible copies of the Instructor's Time Table, Advertising Flier, List of Participants, Mailer, and Certificate of Completion are in Appendix A.

THE SESSION

Time

This module, if presented as written, is three hours in length. It may be presented in a single three-hour session, with a 15-minute break after one-and-three-quarter hours, or in three one-hour sessions.

Each module contains a five minute time allotment for opening each hour session, and a five minute time allotment for closing each hour session. If a module is being presented in one three-hour session, the instructor should eliminate the closing time allotment from hour one and the opening time allotment for both hours two and three in order to gain 15 minutes to use for the break. The 15-minute break should occur between presentation of the second and third hours of the module.

It is important to start and end each session on time. Estimates of presentation time are written in the left hand margins for specific segments or activities within each hour. However, the instructor may choose to expand on one or more of these segments or activities while shortening others.

Remember that a limited amount of information that is thoroughly presented will be more meaningful for participants than a larger quantity of information that has been inadequately understood by the participants.

Handouts/Overheads

Each training module comes complete with specially designed handouts. Since the modules complement one another, some handouts and booklets are recommended for use with more than one module. Reproducible originals of these materials are included in each of the appropriate modules. The Curricula booklet is available separately. The instructor should monitor and make decisions regarding reproduction and distribution of all handouts. The instructor also should supplement them with others that are appropriate.

When deciding which of the original handouts to reproduce as overhead transparencies, the instructor should choose only those with print large enough to be seen and

easily read when projected on a screen. Many of the originals are not suited for use as overhead transparencies.

It is suggested, in a time saving effort, that all handouts be compiled into a single packet and distributed at the beginning of the first hour if the entire three-hour module is being presented, or at the beginning of each one-hour session if the module is being presented in one-hour segments. Only the handouts that will be discussed during the presentation should be reproduced and handed out. Some of the handouts present main points but are designed so that participants can use them for note taking. This should be called to the attention of the participants when appropriate.

MITCH printed materials may be reproduced and used in a manner that best meets the needs of the participants. Reproducible originals of handouts, overheads, and booklets (excluding the Curricula booklet) are in Appendix B of each module.

Videotapes

Videotapes have been chosen to supplement the material of several of the modules (Modules 1, 2, 3, 4, 6, 7, 8, 9 and 13). All of the tapes will provide valuable information for the instructor, even if the videotape is not used during presentation of the three-hour module. Therefore, it is important for the instructor to view the tape that is associated with a specific module prior to presenting the module.

The videotapes have not been included in the designated time allotments suggested in each of the module manuals. The instructor may wish to substitute all or a part of a videotape for material written in the module, extend the three-hour time period, show the videotape at another session, or leave the videotape with the participants to watch as follow-up. See the Specific Information section of each module regarding the videotape for that module. Videotapes may not be copied without written consent of the producer. Information for obtaining videotapes is also provided in the Specific Information section.

Audiotapes

Audiotapes are recommended for the presentation of Modules 5 and 7. See the Specific Information section of each of those modules regarding the audiotapes. The audiotape presentations have been built into the designated time allotments suggested in each of the module manuals.

MITCH Theme Music

Included on the reverse side of the two audiotapes, one each in Module 5 and Module 7, is a three-minute segment of the MITCH theme music. The instructor may wish to play this as participants enter the session, as a signal to return from the break, or in any other suitable manner.

Attendance

At the opening session of each three-hour module, participants should sign the List of Participants form (see Appendix A). The instructor should use this form to verify attendance for all three hours of training and completion of the Six Week Follow-Up Activity.

Six-Week Follow-Up Activity

Three to four weeks after presenting the training module, the instructor, or another person representing the training agency, should contact all participants to remind them to submit their final Six-Week Follow-Up Activity (see Appendix C). This may be done by phone or by mail using the prepared mailer (see Appendix A).

The instructor, or some other qualified person designated by the instructor, should evaluate the quality and content of the performance of the Six-Week Follow-Up Activity by each participant. This may be done by a visit to each participant's place of work or by having each participant mail the completed follow-up activity form to the instructor. The instructor will prepare and give a Certificate of Completion to every participant whose performance meets the instructor's criteria.

Certificate of Completion

Only those participants who attend all three hours of training and who successfully complete the Six-Week Follow-Up Activity are eligible to receive a Certificate of Completion (see Appendix A).

Record of Completion

The instructor should keep the completed List of Participants forms on file in the training agency. Information should be retrievable by the participant's name.

Specific Information for Presenting Module 13

GOALS AND OBJECTIVES

Goal for Hour 1: Participants will gain knowledge of the development of an unborn baby and the possible effects of cocaine use by the mother.

Objectives - Participants will gain an understanding of:

- cocaine
- prenatal development
- the effects of cocaine on the mother
- the possible effects of cocaine on development.

Goal for Hour 2: Participants will gain knowledge of characteristics of infants and toddlers exposed before birth to cocaine and methods of intervention.

Objectives - Participants will gain an understanding of:

- how to recognize and identify infant states of behavior
- strategies for intervention to promote healthy development of infants
- what is known and what is not known about the carryover effects of cocaine
- the role of the caregiver.

Goal for Hour 3: Participants will gain knowledge of environmental effects on infants and toddlers.

Objectives - Participants will gain an understanding of:

- how to recognize and identify the characteristics of a healthy environment
- strategies for promoting a healthy environment
- the importance of accepting each child without labeling any child as a "cocaine baby."

OTHER RECOMMENDED INSTRUCTORS

Because of the nature of the content of this specific three-hour module, the training agency presenting this module may wish to contact other specialized persons within its local area who are willing to perform this duty, such as:

- physicians, nurses, or early interventionists who have experience working with infants and toddlers exposed to substance abuse.

CONTACT LIST

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EQUIPMENT, MATERIALS, AND SUPPLIES

Equipment

This module can be enhanced with the equipment listed below:

- overhead projector
- projection screen or alternative
- audiocassette recorder.

Supplies

The instructor should also have the following supplies available:

- chalk
- crayons or markers
- overhead (transparency) pens
- chart paper
- extension cord
- 3 prong/2 prong adapter plug
- masking tape
- transparent tape
- thumb tacks
- extra batteries
- extra pencils for participants.

Materials Contained in This Manual

The following materials are contained in this manual:

- reproducible forms (Appendix A)
- reproducible handouts/overheads and booklets (Appendix B)
- reproducible Six-Week Follow-Up Activity forms (Appendix C).

Videotape

The videotape, *Cocaine's Children*, was selected to complement this module. Use of this videotape is optional. It is 9:35 minutes in length. Dr. Ira Chasnoff, Associate Professor of Pediatrics and Psychiatry at Northwestern University Medical School and Director of the Perinatal Center for Chemical Dependence at Northwestern Memorial Hospital in Chicago, is the narrator. This film discusses and illustrates the immediate effects of cocaine on the fetus, its early effects on the newborn, and its long-term effects.

Point out to participants that research conducted since this videotape was made suggests that with quality intervention, cocaine-exposed children may expect a normal, healthy outcome.

A copy of this videotape may be borrowed from the Clearinghouse/Information Center, Bureau of Education for Exceptional Students, Florida Department of Education, 622 Florida Education Center, Tallahassee, FL 32399-0400; phone (904)488-1879, Suncom 278-1879, or from any local FDLRS Associate Center.

Copies are also available in 16mm sound, 1/2" videocassette, and 3/4" videocassette formats for free loan from your local March of Dimes Chapter, or for purchase, from the Supply Division, March of Dimes, Birth Defects Foundation, 1275 Mamaroneck Avenue, White Plains, New York, 10605; phone (914) 428-7100.

Materials Not Contained in This Manual

In order to present this module, the following materials, which are not included in the packet, need to be obtained by the instructor:

- several life-sized dolls and blankets for group activity (Hour 2).
- one orange or other piece of fruit or vegetable for each participant for group activity (Hour 3).

Module 13
INTERVENTIONS FOR CHILDREN AT RISK DUE TO SUBSTANCE EXPOSURE: Dealing with the Myth of Cocaine

Hour 1

Goal: **PARTICIPANTS WILL GAIN KNOWLEDGE OF THE DEVELOPMENT OF AN UNBORN BABY AND THE POSSIBLE EFFECTS OF COCAINE USE BY THE MOTHER.**

Objectives - ***Participants will gain an understanding of:***

- cocaine
- prenatal development
- the effects of cocaine on the mother
- the possible effects of cocaine on development.

5 minutes **GREETING, SIGN IN, AND DISTRIBUTION OF HANDOUTS**

SESSION BEGINS

5 minutes **LECTURE/DISCUSSION: Introduction**

Say: In this three-hour training module, we are going to talk about the impact of cocaine exposure on infants and how this substance affects the mother, her unborn baby, the infant, and the family.

The topic of cocaine use and its effects is very popular these days. We all have heard a lot about what cocaine is and what it does. The problem is, a lot of what we have heard may not be correct, because things often get twisted or exaggerated when they are retold. Also, the latest research shows that much of what we thought was true a few years ago is actually not true at all.

There is much that is known about cocaine and its effects, but there is also much that is not known. During the next three hours, I hope to make clear what experts say is true and what is still in doubt. Some of this information may come as a surprise to you.

Instructor may wish to have the following topics written on the chalkboard or flipchart.

Say: During our first hour, we will discuss:

- the illegal drug, cocaine
- how an unborn baby develops
- the known effects of cocaine on the mother
- the possible effects of cocaine on the development of the unborn child.

In our second hour, we will talk about:

- how to recognize and identify infant states of behavior

- how to work with infants to promote healthy development
- what we know and what we don't know about how cocaine use during pregnancy affects the infant
- the role all caregivers have.

Finally, in the last hour, we will cover information about:

- how to recognize the characteristics of a healthy environment
- how to provide a healthy environment
- very importantly, the significance of accepting each child without labeling any child as a "cocaine baby."

However, before we begin, let's spend a few minutes getting to know one another better. That will improve how we work together as we learn more about children exposed to cocaine.

10 minutes

ACTIVITY: Everyone is Unique

Ask participants to introduce themselves by choosing a word that they feel best describes themselves. The person following does the same thing, but also introduces the preceding person using that person's self-description. Instructor should go first to provide a model.

Say: We are all unique. That is, each of us is an individual, even though we may be one of a group of people all identified as caregivers. We each have our own personality, temperament, likes, and dislikes that are characteristic of us but are certainly not characteristic of all other caregivers. The same is true of children. It is very important that we remember that each child is unique and deserves to be respected for and treated according to that child's distinct characteristics.

Handout/ Overhead 13-1-1

Instructor may choose to discuss **Handout/Overhead 13-1-1** now, or refer to it as terms defined on it occur in the discussions.

5 minutes

LECTURE/DISCUSSION: What is Cocaine?

Say: Persons who abuse cocaine very often also abuse other drugs such as alcohol, marijuana, opiates, amphetamines, tobacco, and caffeine. Therefore, it is very difficult to isolate the effects of cocaine from the effects of other drugs on the unborn baby, and upon the child once it is born. Many of the effects we first thought were caused by cocaine use may be caused by other drugs.

The thing that makes cocaine such a problem is that it is relatively inexpensive, it is readily available and it is easily ingested, or taken. Therefore, it has been used a great deal in the past few years and that is why we are hearing so much about it.

In three hours, we do not have time to go into the effects that all drugs, including alcohol, have on pregnant mothers and their infants and toddlers. However, you should know in some cases these effects can be very harsh. These effects can be harmful to the physical and mental condition of the child. These also can cause the home environment in which the child lives to be unstable and non-nurturing.

Today, because it is so topical we are going to discuss only cocaine and what is known about it, even though we realize that many persons who use cocaine also use other drugs.

It is probably a good idea to begin by getting a clear understanding of what cocaine is. Many of you may already know a lot about this illegal substance.

Ask: Is anyone willing to share what they know?

Using the chalkboard or flipchart to record responses, Instructor leads discussion to include:

- Cocaine belongs to the class of drugs called stimulants. Other examples of stimulants are nicotine, caffeine, and amphetamines.
- Cocaine is quick-acting and a very powerful central nervous system stimulant.
- Cocaine is extracted from the South American coca bush.
- Cocaine is also known as "coke," "rocks," "snow," "blow," and "toot."
- The cocaine that is available in the United States (cocaine hydrochloride) is a pure white crystalline powder. It is usually combined with other substances such as talcum powder, flour, laxatives, sugar, or local anesthetics in order to increase the volume and consequently the price.
- Cocaine is ingested by snorting the powder (breathing in the powder through the nose), injecting it into a muscle or vein, or converting it into a smokable form called freebase.
- Cocaine is used by many people of all races and all socioeconomic levels. Although many people think the problem is associated only with inner-city populations, this is not correct.
- In the United States, cocaine is an illegal drug. Selling it or having it in one's possession is punishable by arrest, fine, or both.

Say: `This discussion has brought to my mind the subject of Crack.`

Ask: `What is crack? Is it the same as cocaine?`

Instructor leads discussion to include:

- Crack is a nearly pure form of cocaine.
- It appears as a light brown or milky white pellet or "rock".
- Crack is smoked.
- It delivers a burst of cocaine to the brain in less than 15 seconds.
- Crack causes a very dramatic "high".
- Users report feeling very powerful and sexually aroused.
- The effects die very quickly and within minutes the user is left craving more.

- The "high" is replaced with a feeling of severe depression, paranoia, and irritability.
- Users can rapidly fall into a cycle that makes them physically and psychologically addicted in as little as two weeks.

The above information on cocaine and crack is from *Florida's Substance-Exposed Youth.*

Handout/ Overhead 13-1-2

Instructor refers to **Handout/Overhead 13-1-2** which summarizes the above information.

10 minutes

LECTURE/DISCUSSION: Prenatal Development

Say: Now, let's take a look at the highlights of prenatal development.

Ask: Are you familiar with how an unborn baby develops?

Instructor leads discussion to include as much of the following information as is necessary to give participants an elementary understanding of the time and sequence of the development of an unborn baby (fetus). Encourage participants to respond and contribute to the discussion.

- During the first few weeks of gestation a cluster of cells implants itself into the mother's uterine lining. These cells will become the baby and the placenta.
- During the fifth to twelvth week of pregnancy (gestation), the brain and spinal cord begin to develop and the heart is formed and begins to beat. Evidence of the bony structure appears. The head is forming and the fingers and toes appear.
- Between the 13th and 16th weeks of gestation, the baby's organs and physical features become present.
- After the 16th week, the changes that take place in the unborn baby are ones of refinement and growth.
- The baby is nourished and receives oxygen by drawing on the mother's blood supply which comes through the placenta, or cord, that connects the baby to the mother.
- The unborn baby is completely dependent upon the mother for nourishment and for the environment in which the unborn baby exists.

- Infants born after 24 weeks of gestation or greater have a good chance of survival if they are given high quality care in a Neonatal Intensive Care Unit (NICU). Babies normally stay in utero 36 to 40 weeks.

Instructor may wish to refer to *MITCH Module 1 - Intellectual Development: What You Can Do to Help, Hour 1*, for additional suggestions or an alternate method for presenting the principles of development and discussing the prenatal, perinatal, and postnatal influences on development here or in Hour 2 of this module.

10 minutes

LECTURE/DISCUSSION: Effects of Cocaine on the Mother and on Prenatal Development

Say: Now, what happens to a mother and to an unborn baby if the mother uses cocaine while she is pregnant?

Cocaine travels in the mother's blood through her blood vessels. It goes to every organ of the mother's body. It goes through the blood vessels of the womb and through the umbilical cord. This can cause the cord to constrict, or get smaller.

Ask: When this happens, what do you suppose the effect is on the unborn baby?

Instructor listens to responses.

Say: Yes, it reduces the flow of blood and oxygen that should be going to the unborn baby. Remember, the unborn baby gets all of its nourishment and oxygen through the umbilical cord. This is one possible explanation for the poor growth of the unborn baby in the womb and for the low birth weight that is often seen in babies exposed to cocaine.

Cocaine, like all drugs, legal and illegal, may affect the development of the unborn child depending upon the dose involved, and the time during development when the drug was used. The mother does not have to be a chronic abuser of drugs for them to harm her baby.

Prenatal exposure to cocaine has been linked to prematurity and low birth weight, breathing problems, and Sudden Infant Death Syndrome (SIDS). It has also been linked to the development of certain birth defects of the gastro-urinary (GU) and gastro-intestinal (GI) systems. These are the systems in our body that have to do with eating, digesting, and eliminating foods and liquids.

If cocaine is used in the first three months of pregnancy, there is an increased chance of spontaneous abortion, or miscarriage. Cocaine used in the last three months of pregnancy is associated with premature labor.

If a mother uses cocaine during the 72 hours just before the child is born, the infant may show signs of central nervous system stimulation, that is, the effects of the drug. These infants may be jittery and irritable, and may have an increased heart rate.

A pregnant woman who uses cocaine exposes the unborn baby to stresses that continue long after the drug is used. One of the by-products of cocaine is a water-soluble substance called norcocaine. It passes from the mother into the fluid in the womb in which the unborn child rests. The unborn baby takes the norcocaine in, over and over again, for days.

Also, the unborn baby also cannot break down the drug as quickly as the mother can, so it stays in the baby's body longer.

Such infants may continue to exhibit behaviors due to cocaine exposure after they are born. They may remain irritable six to eight weeks after birth. They may not respond well to their environments for two to three months. They may show:

- fine tremors
- stiff muscles

- irregular sleeping patterns
- poor feeding patterns
- increased breathing and heart rates
- difficulty sucking and swallowing.

In general, the behavior of these babies is like that of premature infants whether or not exposed babies actually were born prematurely. Cocaine-exposed babies are not able to go from one state of behavior, such as sleeping, to another, such as being alert, easily. We will discuss this more thoroughly in Hour 2 of this module.

10 minutes

LECTURE/DISCUSSION: What We Know About the Effects of Cocaine

Handout/ Overheads 13-1-3 & 13-1-4 or 13-1-5

Instructor refers the **Handout/Overhead 13-1-3** and may request participants to use **Handout/Overhead 13-1-4** in order to write correct responses. Or Instructor may distribute **Handout/Overhead 13-1-5** either before or after the activity. It will be important to get active participation from participants for this summary in order for them to remember what are, and what are not, common characteristics exhibited by infants exposed to cocaine.

Instructor expands upon information to ensure that participants have a clear understanding of each concept. Rather than engaging in a lecture style, encourage participants to explain the concepts to each other.

Possible effects of cocaine use during pregnancy:

- A higher risk of miscarriage in first three months
- During the last three months there can be
  - excessive fetal movement
  - a separation from the womb by the placenta
  - increased blood pressure and heart rate in the baby
- An increased risk of premature labor and delivery.

Cocaine-exposed infants may display behavior similar to those of premature infants, whether or not the cocaine-exposed infant was premature. Use of cocaine CAN result in the following clinical signs in the child. Specifically:

- low birth weight
  - small head circumference (size)
  - shorter stature
- rapid respirations and heart rate
- poor feeding patterns
  - difficulty sucking and swallowing
  - frequent spitting up
  - increased risk for failure to thrive
- poor sleeping patterns
  - difficult to wake up or hypersensitive
  - difficulty sleeping through the night
  - irregular sleeping patterns
- poor state control
  - decreased length of calm state
  - frequent startles
- poor visual and auditory attention
  - poor eye contact
  - frequent gaze aversion
  - poor visual scanning
- hypersensitivity or irritability
  - high-pitched, excessive crying
  - increased sensitivity to environmental stimuli, e.g., noise, lights, handling
- difficulty in comforting self and in being comforted
- depressed interactive abilities
  - decreased smiling
  - decreased vocal sounds and gesturing
- decreased quality of movement
  - tremors
  - jitteriness
  - poor eye/hand coordination
- increased muscle tone and stiffness
  - delayed motor development
  - increased arching

Instructor returns to list of the effects of cocaine that was made on the chalkboard or flipchart earlier in the hour. Cross out any information that is incorrect

Say: Now, here is another important piece of information on the effects of cocaine use on an unborn child.

Recent information shows that many children exposed to cocaine before they were born can develop into physically intact, thriving children, particularly if they have had a loving, stable environment with a consistent, responsive caregiver.

It will be important to watch for long-term research to see what it tells us about effects cocaine-exposed children may show as they get older.

Many factors need to be considered when looking at the future of children exposed to cocaine:

- One factor is the personal characteristics and ability of the primary, or main caregiver.
- A second factor is the home or major environment and how it impacts upon the development of the child.
- A third factor is the quality and availability of services for the child.

We will be talking about these factors in the next two hours.

5 minutes
(omit if 3-hour presentation)

END OF HOUR 1: Closing

Module 13

INTERVENTIONS FOR CHILDREN AT RISK DUE TO SUBSTANCE EXPOSURE: Dealing with the Myth of Cocaine

Hour 2

Goal: **PARTICIPANTS WILL GAIN KNOWLEDGE OF CHARACTERISTICS OF INFANTS AND TODDLERS EXPOSED BEFORE BIRTH TO COCAINE AND METHODS OF INTERVENTION.**

Objectives - ***Participants will gain an understanding of:***

- how to recognize and identify infant states of behavior
- strategies for intervention to promote healthy development of infants
- what is known and what is not known about the carryover effects of cocaine
- the role of the caregiver.

5 minutes
(omit if 3-hour presentation) **GREETINGS, SIGN-IN, AND DISTRIBUTION OF HANDOUTS**

SESSION BEGINS

10 minutes **LECTURE/DISCUSSION: Infant States of Behavior**

Say: During the second hour of this module, we will talk about:

- how to recognize and identify states of behavior
- strategies for intervention to promote healthy development of infants
- what we know and what we don't know about the carryover effects of cocaine
- the role of the caregiver.

Some of the most frequently raised questions from caregivers of the child at risk due to cocaine exposure are "Where do we begin our intervention?" and "How do we begin to work with these children?" Let's talk about that.

First, there must be a realization that, as a group, cocaine-exposed children are basically no different than any other group of children. Just as other children, these children are born with a set of inheritances unique to them.

Ask: What are some of the factors that influence the health of the newborn?

Instructor leads discussion and records responses on chalkboard or flipchart. Include:

- the genetic makeup of the mother and father
- the health of the mother at the time of conception and during pregnancy
- the quality of prenatal care received by the mother during pregnancy
- the developmental state of the unborn baby at the time of drug (legal or illegal) use by mother
- the type of drug (legal or illegal) and dose.

Say: These factors can be positive or negative. They contribute greatly to the response a child will have if there is prenatal drug exposure. They dictate to a great extent how vulnerable the child at risk will be.

During our last hour, we described some of the characteristics that we might see in cocaine-exposed infants.

Ask: What is the overriding factor that is important to remember?

Instructor should emphasize that the one characteristic that seems to be consistent is these babies exhibit behavior that is very similar to that of premature infants. They also may or may not show other specific behaviors such as those previously discussed.

Say: Children at risk due to exposure to cocaine may exhibit all, some, or none of the symptoms or behaviors we have discussed. As caregivers, we must look at the symptoms any newborn exhibits as cues or signals for how we respond to that child.

For example, if a child was born with low birth weight, we know that we would need to pay special attention to the child's eating patterns, food intake, and gains or losses in weight. If a child seems stiff or rigid, we will want to help the child relax by swaddling and placing the child in a flex position, rocking the child in a horizontal pattern, talking softly, avoiding startling situations, and so on.

Also, babies themselves can give us cues or signals that can tell us what state they are in. It is important to use these cues to help us know how to respond to the child.

Ask: What are some obvious cues that you recognize in newborns?

Instructor leads brief discussion to include such examples as:

- crying may indicate discomfort or expression of a need
- gazing toward or away from may indicate desire for approach or avoidance of another person or object
- stiffness or a relaxed state may indicate physical discomfort or comfort.

Say: A famous developmental pediatrician, Dr. T. Berry Brazelton, has done much work with infants and their caregivers. He has studied infant behavior and has identified certain behavioral states that all infants seem to have.

Handout/ Overhead 13-2-1

Instructor refers to **Handout/Overhead 13-2-1**.

Say: He suggests that babies have two sleeping states. One is deep sleep. In this state, the baby's eyes are closed and there are no spontaneous movements other than startles or jerks. External stimulation, such as a touch or a loud sound, will cause the infant to startle. Then, after startling, the infant often will return to a deep sleep.

The second state is a light sleep where the eyes are still closed but the baby may make some random movements. You might be able to see some eye movements under the closed lids. When stimulated, a baby in this state may easily move to an awake state.

Dr. Brazelton has observed four awake states. The first of these is what is called the drowsy or semi-dozing state. The infant's eyes may be open but they are dull and heavy-lidded. The activity level is low. Response to stimulation is variable from delayed or slow, to mild startles. Usually a baby will become more fully awake when stimulated in this state.

The next awake state is called the alert state. In this state the baby has a bright look and seems to

focus on, or look at, the source of stimulation, such as a face, or an item to be sucked.

The following state is characterized by wide-open eyes and considerable movement, or motor activity. Legs and arms move in thrusting motions. The infant may make some vocalizations.

The fourth and final awake state is that of crying. You are all familiar with that! This state is characterized by intense crying which is difficult to break through with outside stimulation. There is also much motor activity.

Dr. Brazelton and his associates have discovered important information about the pattern of states a newborn has, and how the infant moves from one state to another. The child's state and ability to manage movement between states is basic to the child's quality of life.

A neurologically intact, or well-organized, infant has the ability to control the level of outside stimulation by the use of state. For example, a baby should easily return to a deep sleep state, after a startling noise or easily go from sleep to alertness.

But an infant that cannot control the level of outside stimulation by the use of state will be at the mercy of the environment. Such infants cannot protect themselves from the stress of too much stimulation. They may have difficulty going from one state to another. A child may be startled awake from a deep sleep and go immediately to the state of intense crying.

These infants may be very difficult for a caregiver to handle. So, in addition to not being able to regulate their own environment by shutting out high levels of stimulation, these difficult babies may be at risk for neglect or abuse by caregivers who feel frustrated by the babies' behavior.

5 minutes **ACTIVITY: Role-Play**

Say: I'd like to illustrate something.

Instructor divides participants into two groups. Without letting persons from one group hear, tell the members in the other group to play the role of caregivers who are very persistent in trying to comfort a crying child. Again, without letting anyone in the first group hear, instruct the persons in the second group to be crying infants who will not be comforted, but continue to be difficult by turning away, averting eye contact, displaying stiff muscle movements and an arching back type of posture. Then pair persons from the first group with persons from the second.

After allowing the players to continue the role-play for two to three minutes, long enough for members from both groups to begin to feel frustrated, confused, and even angry, stop the role-play. Ask the participants to talk about how they felt. Assist them in understanding how this situation could lead to feelings of rejection and stress for both the infant and caregiver and then to neglect or abuse behaviors on the part of the caregiver.

20 Minutes **ACTIVITY: Intervention with Newborns**

Say: Premature babies and other infants who are born with immature, underdeveloped, or damaged neurological systems will have difficulty with being able to regulate their state and, thus, in having some control over their environment. You will remember in Hour 1, we said cocaine-exposed infants also tend to have this difficulty. All of these infants are under stress. All of them are at risk for abuse. All of them need careful attention.

Even though we are gathered here to talk about children who are at risk because of exposure to cocaine, it is important for us to also understand that all children need careful attention. Whether or not they were premature or delayed, all children will display stress behaviors at one time or another. Children described as being difficult simply tend to display this behavior more often.

So, what we are going to discuss now will help you with all of the infants with whom you work.

For a moment, let's talk about some of the cues infants may give us, and what they may mean.

Instructor describes behavior and asks participants to interpret the meaning of the behavior.

When presented with a stimuli (e.g., loud noise, object to view, bright light) and the baby:

- becomes still and brightens, it may mean the baby is alert and interested
- turns toward stimuli, it may mean the baby is seeking or is receptive to interaction/stimulation
- gazes toward stimuli, it may mean the baby is seeking interaction/stimulation
- stiffens, it may mean the baby is interested or is wary
- stiffens and arches back, it may mean the baby does not want interaction/stimulation
- resists being held or cuddled, it may mean the child is sensitive to touch or does not want interaction
- closes eyes tightly, it may mean the baby does not want interaction/stimulation.

Say: Now, let's learn and practice some good intervention techniques.

Instructor divides participants into three to four groups. Give a life-sized baby doll and baby blanket to each group. As intervention techniques are discussed, have participants take turns within their groups demonstrating and practicing techniques such as swaddling and rocking the doll appropriately.

Handout/ Overhead 13-2-2 through 13-2-6

Instructor uses **Handout/Overheads 13-2-2 through 13-2-6** to guide this activity and discussion. Spend as much time as necessary to insure that each participant has a good understanding of each of the many concepts that are presented.

Ask: Are there any questions?

5 minutes

LECTURE/DISCUSSION: Sensory Integration

MITCH Module 5 - Listening and Sensory Integration: What to Do Before Speech and Language Develop covers this topic extensively. Instructor may wish to review some of that material here.

Say: An aspect of development that is important to consider with infants is sensory integration. Sensory integration is a process which allows the newborn to interact with and learn from the world.

Sensory integration means using the senses of touch, vision, hearing, taste, smell, and balance in an organized way. Humans take in information through the senses. The ability to make use of the information in an orderly and meaningful manner depends upon how well the central nervous system is formed and how well it works. You will remember that this system begins to develop very early in pregnancy and it continues to be refined up to birth. Babies who are born prematurely, and babies whose nervous systems may have suffered an insult during pregnancy, may not have the full ability to integrate or make use of sensory information that comes from the environment. This will have a negative impact on how the baby interacts with and learns from the world. These infants may need some special help in getting their sensory systems to work better.

One of the things that we, as caregivers, can do to help an infant develop a better system of sensory integration is to provide opportunities for the infant to practice. Let us review some activities that will help us do this.

Handout/ Overhead 13-2-7

Instructor refers to and discusses **Handout/Overhead 13-2-7.**

Ask: Are there any questions?

10 minutes

LECTURE/DISCUSSION: Carryover Effects of Cocaine in Children

Say: For the past two hours, we have been talking about how cocaine use can affect unborn babies and

infants. What about toddlers and older children? What do we know?

Actually, we don't know very much. At one time, we thought that all children who were exposed to cocaine would show signs of this exposure. We thought that they would all be delayed in development, that they would be poor learners, and that they would be doomed for life. Happily, we are finding out that is not true.

Long-term research studies that follow the development of cocaine-exposed infants as they grow to be young adults are not yet available. However, we have seen many, many cases where it appears that good management and early intervention are very helpful.

Some children heavily exposed to cocaine before birth who have had the benefit of good care after they were born seem to be doing very, very well. They appear to be developing as well as their friends who were not exposed to cocaine.

Ask: Why do you think this can happen? What makes the difference in how one child who has been exposed to cocaine develops as compared to another?

Instructor leads discussion to include:

- all prenatal variables discussed previously, especially amount and timing of drug exposure
- proper early intervention
  - using of sensory integration techniques
  - being sensitive to cues given by infant
  - working with the infant often but in keeping with the infant's own schedule and timing
  - being persistent and consistent with developmentally appropriate practices
- stable, caring, nurturing environment
  - consistent, loving primary caregiver
  - routine in the daily schedule
  - consistent behavior management

- meeting of basic needs (food, shelter, sleep) in comfortable, adequate setting.

Say: You can see that the things that make a difference in the life of a cocaine-exposed child are no different than the things that make a difference in the life of any child. All children have a better chance to grow and learn in a healthy, happy, stable environment, than they do in one that is depressed, steeped in poverty, or chaotic.

Ask: Knowing all of this, what would you now say about your role as a caregiver in making a difference in the life of a cocaine exposed child, or in the life of any child?

Instructor allows participants to respond and then summarizes.

Say: Yes, we all have a big role. We have a chance to make a difference in how children develop and in how well-equipped they will be in meeting the demands of the future as they grow up.

In the final hour of this module, we will continue to see how we can make that difference.

Ask: Are there any questions?

5 minutes
(omit if 3-hour presentation)

END OF HOUR 2: Closing

Module 13
INTERVENTIONS FOR CHILDREN AT RISK DUE TO SUBSTANCE EXPOSURE: Dealing with the Myth of Cocaine

Hour 3

Goal: **PARTICIPANTS WILL GAIN KNOWLEDGE OF ENVIRONMENTAL EFFECTS ON INFANTS AND TODDLERS.**

Objectives - ***Participant will gain an understanding of:***

- how to recognize and identify the characteristics of a healthy environment
- strategies for promoting a healthy environment
- the importance of accepting each child without labeling any child as a "cocaine baby."

5 minutes
(omit if 3-hour presentation)

GREETING, SIGN IN, AND DISTRIBUTION OF HANDOUTS

SESSION BEGINS

10 minutes

ACTIVITY: Orange Attachment

Say: In the preceding hours of this module you learned about cocaine use and the possible effects upon the mother, the unborn baby, and the child, and about intervention strategies with cocaine-exposed infants. In this third hour, you will learn how to recognize and identify the characteristics of a healthy environment, strategies for promoting a healthy environment, and the importance of accepting each child without labeling any child as a "cocaine baby."

One of the most important elements of a healthy environment for an infant is the interpersonal environment, or the relationship that the infant has with the primary caregiver. Usually, the primary caregiver, the person who provides the most care for any infant, is the mother. However, this is not always true. Other persons who can be primary care providers are fathers, grandmothers, foster parents, or even older brothers or sisters.

What is very important is that the infant feels secure in this relationship with the primary caregiver. We call the process of developing a strong relationship bonding, or attachment. I'd like to take a few moments to make sure the concept of attachment is meaningful to you.

This activity demonstrates how instinctive the bonding process is. After studying an orange for only a few minutes, participants will find they can pick out their own orange from a pile of many oranges.

Instructor must either provide an orange for every participant, or ask each to bring one in. Participants are asked to study their individual orange and "bond" to it by looking it over carefully, feeling it, and observing distinguishing features. Then, after 30 to 60 seconds, instructor should collect all of the oranges and deposit them in a pile in

one place. Participants then come up at one time to collect their own orange from the pile, and return with it to their seat. Generally, in a group as large as 30 people, all participants will identify their own orange in less than one minute. Key limes or other fruits or vegetables may be used instead of oranges as long as every person has the same type of fruit or vegetable.

Use this activity to point out how natural and strong the bonding instinct is. Emphasize that such a relationship is very important to the healthy development of an infant. If there are too many incidental caregivers, or if the primary caregiver is unstable and inconsistent so that the caregiver seems different each time the infant has contact with that caregiver, the infant may not successfully bond with that caregiver. The infant will experience the feelings that participants had who could not at first find their own orange. Discuss the implications of this and how this may lead to feelings of helplessness, hopelessness, and withdrawal.

Module 7 - Behavior Management: Preventing and Dealing with Problem Behavior, discusses the process of attachment at length. The Instructor may wish to review some of that material here or arrange to present that module to the same group of participants at another time.

15 minutes

LECTURE/DISCUSSION: Emotional Development

Say: We said infants tend to attach to a primary caregiver. They also can attach to a network of caregivers and even to objects such as a favorite blanket or teddy bear. Whomever or whatever the child has bonded to provides a sameness, or a source of security and comfort.

Attachment and emotional development are closely related. Children who are securely attached tend to develop a healthier emotional life.

Secure attachment is also positively related to cognitive or intellectual development. It seems that children who feel secure also feel more comfortable in exploring their environment and in establishing relationships with other persons. As you know, exploration is a primary way for infants and toddlers to learn. When they feel secure,

infants have a base from which to orient themselves and then move out into the world. Securely attached infants tend to be more resourceful, flexible, socially competent, and successful on developmental or intelligence tests than do infants and toddlers who are not well attached.

Ask: What do you think are some important factors in forming a secure relationship with an infant?

Instructor stresses the importance of reciprocity between infant and caregiver (meeting needs of infant and caregiver). Include:

- eye contact
- cuddliness
- responsiveness to auditory, visual, and tactual stimulation
- facial expressions
- vocalizations
- recognizing crying as a signal
- routine
- familiarity
- nurturing
- consistency
- being available when needed.

Say: Children who are at risk or delayed may have difficulty with the attachment process. This is because they may lack the strength or ability to respond.

Likewise, parents who abuse legal or illegal drugs, or who are otherwise under serious stress, may have difficulty in meeting the demands of a healthy attachment. This is because other events in their lives compete for attention. These events may be either very strong or overwhelming.

Such parents, even though they wish to do so, may have difficulty providing the stable, loving

environment in which children thrive. If drug abuse continues in the home, the situation can be chaotic and unpredictable for the infant. This may lead to serious problems.

Handout/ Overhead 13-3-1

Ask: What happens then? What do children without secure attachment look like and how might they act?

Instructor refers to and discusses **Handout/Overhead 13-3-1.**

Say: Rather than spending time talking about all of the harmful situations that can occur in the environment, we will discuss the positive events that promote the healthy growth of any child. By focusing on the positive, we can know better what specific things we can do as caregivers to foster a good attachment between caregiver and child, and to promote a healthy self-concept in the child. You, as the caregiver, can provide a stable, loving environment for a child who may not otherwise be getting one. You can also enrich the environment of those who do have a safe and healthy home situation.

Let's discuss some ways we, as caregivers, can do something about improving the environment of a child without secure attachments.

Handout/ Overhead 13-3-1 (con't)

Instructor asks participants for suggestions, then refers to and discusses **Handout/Overhead 13-3-l, cont'd.** Spend as much time as necessary to ensure that participants understand all of the concepts presented.

Say: We have talked about several ways to promote a healthy environment through nurturing. Nurturing is one of the most important elements in the process of attachment. Children who are nurtured generally feel a bond with the person who is doing the nurturing. The nurturing and the bonding with the caregiver contribute to the child's sense of security and sense of self worth.

The long-term positive effect of working properly with these infants and toddlers is to help them develop a strong self-concept. Caregivers have the opportunity to provide an environment that can

make all children feel good about themselves and who they are. Such feelings of self worth are very important factors in how well the child does in the future.

Caregivers are very influential people in the lives of children.

20 minutes

ACTIVITY: Intervention Strategies

Say: To help parents and other caregivers understand how they become role models to strengthen the growth and development of children exposed to cocaine, the Florida Department of Education compiled a publication entitled *Cocaine Babies: Florida's Substance-Exposed Youth.* In that booklet, the work of a team of people from the Program for Children Prenatally Exposed to Drugs (PED) in the Los Angeles Unified School District is reported. The intervention techniques we are going to discuss next are based on their activities and on others cited in the publication.

For example, in addition to bonding, they talk about other aspects of the environment that can affect the development of a child. A very important consideration is the structure or order of the environment in which children grow. Many children live in an environment that is chaotic or disordered. This can make a child feel insecure.

Ask: What are some strategies you can think of that would assist infants and toddlers in organizing their environments?

Handout/ Overhead 13-3-2

Instructor refers to and discusses **Handout/Overhead 13-3-2**. Have participants give specific examples of each strategy as it is discussed. Model any with which they may be unfamiliar.

Say: Children who are at risk need a setting in which transition from one activity to another actually is seen as an activity in and of itself. As such, these transitions have a beginning, a middle, and an end. Special preparation must be given to

transition time. It should be recognized as one of the best times of the day to teach the child how to prepare for and cope with change.

Ask: What are some things you can do to make sure transition time is successful as well as meaningful as a time to learn?

Instructor leads discussion to include:

- allowing plenty of time
- warning children an activity will be ending
- identifying what will come next (where children should go, what behavior is expected)
- giving verbal cues
- using auditory (musical toys, pleasant bell) or visual (light dimming, flag waving) signals
- marking the beginning of the new activity
- carefully overseeing transitions
- being mindful of time and schedules (don't keep children waiting, make transitions at appointed time on schedule).

Ask: What special transition techniques do you use?

Instructor encourages sharing of information.

Handout/ Overheads 13-3-3 through 13-3-7

Instructor repeats the above question/answer/modeling procedure with one or more of the topics presented on **Handout/Overheads 13-3-3 through 13-3-7.** When possible, have participants stand to model a concept, share an idea, or otherwise move about and get hands-on practice. Encourage participation and contribution of ideas from all.

Ask: Are there any questions?

5 minutes

LECTURE/DISCUSSION: Accept each child without labeling any as a "Cocaine Baby."

Say: Throughout this training we have had one major point we have wanted to make about cocaine-exposed infants and toddlers.

Ask: Can you identify what that is?

Instructor accepts responses and continues.

Say: Yes. We want everyone to recognize that all children are unique. Each child has strengths, weaknesses, needs, and abilities. We know that cocaine-exposed children may be born with a range of abilities and a range of symptoms from no symptoms, at least none that are apparent, to some that may be fairly severe. The same is true for any child.

Ask: Why is it important not to label a child as a "cocaine baby?"

Instructor leads discussion to include:

- labels tend to make us overlook individual symptoms and treat everyone the same even if the treatment is inappropriate
- labels may be false
- labels don't give us any information about how to intervene
- labels may stigmatize a child or family, resulting in others rejecting or finding fault with them instead of working with them.

Say: Proper care and attention is necessary to make any child a thriving, intact individual. Remember, there is not a single set of characteristics that all children have. As a result there cannot be one set of interventions or way of working with them.

Ask: What general principle have you learned about how to work with children?

Instructor listens to responses.

Say: Yes. Strategies for intervention must be based upon the strengths, weaknesses, needs, and concerns of the individual child and family. Every effort must be made to provide children with a nurturing, secure, self-enhancing, stable environment.

The essential ingredient in building a nurturing environment is a caregiver who is available, affectionate, knowledgeable, and loving. Such a caregiver must know how to meet the behavioral,

social, medical, psychological, and emotional needs of infants and toddlers. There must be dedication and a commitment to create a healthy environment in which all children, regardless of their circumstances, can develop to their highest potential.

As we complete the third hour of this module, let's review a few of our main points. Ironically, perhaps there is one positive thing that cocaine has done for our society. It has called our attention to the very serious problem of substance abuse as it relates to crack cocaine. Crack is quick to bring on euphoric results, relatively inexpensive, and highly addictive. Crack cocaine became one of the most talked about social problems of the decade and more and more people seem to have become drug abusers. However, as we came to learn more about this phenomenon of cocaine abuse, it became clear to the majority of us what previously only a few persons who worked with drug abusers knew.

First, cocaine is only one of the many drugs that can cause problems for our children by altering the physical and mental environment in which they grow from conception through young adulthood. Alcohol is another. Marijuana, heroin, opium, and many legal drugs that are prescribed by physicians but which are abused by the user, are other harmful substances. Many abusers of one substance (e.g., cocaine) also abuse many other drugs.

Second, and for our purposes more importantly, the most critical factor for you in working with children is to look at each child and relate to that child according to that child's unique strengths and weaknesses. Bear in mind that all children require love, nurturing attention, and developmentally appropriate programming.

You can be the caregiver that makes a difference in the life of every child you touch. We hope you

have some new inspiration and skills for doing so from this training. Best wishes!

5 minutes

Explanation of Six-Week Follow-Up Activity

Give participants the phone number at which you can be reached should there be any questions regarding the follow-up activity.

END OF HOUR 3: Closing

Resource List

Alcohol and Drug Abuse Program, State of Florida Department of Health and Rehabilitative Services (HRS), 1317 Winewood Blvd. Tallahassee, FL 32399-0700, (904) 488-0900, SunCom 278-0900. Contact Terri Goens, Senior Human Services Program Specialist.

Arnold Palmer Hospital for Children and Women, 92 West Miller St., Orlando, FL 32806, (407) 841-5111 ext. 6029. Contact: Dr. Frank A. Lopez, Assistant Director of Medical Education, and Specialist in Development, or Dr. Robert L. Maniello, Co-Director of Newborn Nursery, and Director of Ambulatory Pediatrics.

Bettelheim, B. (1987). A good enough parent. New York: Alfred A. Knopf.

Cocaine babies: Florida's substance-exposed youth. Office of Policy Research and Improvement, Florida Department of Education, Tallahassee, FL. For a copy, contact Dan Thomas, 414 Florida Education Center, Tallahassee, FL 32399-0400. Phone: (904) 488-7835.

Crack Kids. (1991, May). Time Magazine, 137(19), 56-60.

Drug-Exposed Children's Committee, Hillsborough County Schools, 411 Henderson Avenue, Tampa, FL 33602, (813) 272-4577, SunCom 547-4577. Contact: Linda Delapenha, Supervisor, Diagnostic Services, Hillsborough County Schools.

Florida Alcohol and Drug Abuse Association, 1286 North Paul Russell Road, Tallahassee, FL 32301, (904) 878-2196. Contact: Cindy Colvin.

Juvenile Welfare Board of Pinellas County, 4140 49th St. N., St. Petersburg, FL 33709, (813) 521-1853. Contact: Kate Howze, Community Relations Specialist.

Kennell, J., Voos, D., & Klaus, M. (1976). Parent and infant bonding. Perinatal Center for Chemical Dependence, Chicago, IL - various handouts.

March of Dimes Birth Defects Foundation, Community Services Department, 1275 Mamaroneck Ave., White Plains, NY 10605, (914) 428-7100. See also local chapters.

National Association of Perinatal Addiction Research and Education (NAPARE), 11 E. Hubbard St., Suite 200, Chicago, IL 60611, (312) 329-2512. Contact: Eileen Ward (for scheduling) or Pat O'Keefe (public information).

National Clearinghouse for Alcohol and Drug Information, Post Office Box 2345, Rockville, MD 20852, (301) 468-2600.

Salvin Education Center, 1925 S. Budlong Ave., Los Angeles, CA 90007, (213) 731-0703.

Snowbabies, Inc., P.O. Box 162856, Altamonte Springs, FL 32716-2856, (407) 331-5577.

HOTLINE: (800)-COCAINE, 24-hour toll-free information and referral service for Florida specific information regarding prenatal care and dangers of substance abuse during pregnancy. (See also above reference for the Office of Policy Research and Improvement).

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Chasnoff, I. J., Griffith, D. R., MacGregor, S., Dirkes, K., & Burns., K. (1989). Temporal patterns of cocaine use in pregnancy. Journal of the American Medical Association, 261, 1741-1744.

Chasnoff, I. (1988). Newborn infants with drug withdrawal symptoms. Pediatrics in Review, 9(9), 273-277.

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Chasnoff, I. J., Bussey, M. E., Savich, R., & Stach, C. (1986). Perinatal cerebral infarction and maternal cocaine use. Journal of Pediatrics, 456-459.

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Cocaine babies: Florida's substance-exposed youth. Office of Policy Research and Improvement. Florida Department of Education, Tallahassee, FL.

Crack Kids. (1991, May). Time Magazine, 137(19), 56-60.

Davidson-Ward, S. L., Schultz, S., Krishna, V., et al. (1986). Abnormal sleeping ventilatory pattern in infants of substance-abusing mothers. American Journal of Diseases of Children, 140, 1015-1020.

Fact Sheet: Alcoholism, other drug addictions, and related problems among women. (1990). National Council on Alcoholism and Drug Dependence, Inc.

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Flandermeyer, A. A. (1987). A comparison of the effects of heroin and cocaine abuse upon the neonate. Neonatal Network, 42-48.

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Harrison, H. (1983). The premature baby book. St. Martin's Press: NY.

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Regan, D. O., Ehrlich, S. M., & Finnegan, L. P. (1987). Infants of drug addicts: At risk for child abuse, neglect and placement in foster care. Neurotoxicology and Teratology, 9, 315-319.

Schneider, J. W., & Chasnoff, I. J. (1987). Cocaine abuse during pregnancy: Its effects on infant motor development - A clinical perspective. Top Acute Care Trauma Rehabilitation, 2(1), 59-69.

Scott, K. G., Urbano, J. C., & Boussy, C. A. (1991). Longterm psychoeducational outcome of prenatal substance exposure. Seminars in Perinatology, 15(4), 317-323.

Smith, J. (1988). The dangers of perinatal cocaine use. The American Journal of Maternal and Child Nursing, 13, 174-179.

Snowbabies, Inc., P.O. Box 162856, Altamonte Springs, FL 32716-2856, (407) 331-5577.

Sproat, K. V. (Ed.) (1989). Special currents: Cocaine babies.

Van Baar, A. L., Fleury, P., Soepatmi, S., Ultee, C. A., & Wesselman, P. M. (1989). Neonatal behavior after drug dependent pregnancy. Archives of Disease in Childhood, 64, 235-240.

Van Baar, A. L., Fleury, P., & Ultee, C. A. Behavior in first year after drug dependent pregnancy. Archives of Diseases in Childhood.

Appendix A

Reproducible Forms for Three-Hour Module

Form	Copies to make
• Instructor's Time Table and Notes (2 pages)	• 1 per instructor
• Advertising Flier	• As needed
• List of Participants	• Varies - usually 6 to 8
• Follow-Up Mailer (2 pages)	• One per participant

Note: Reproduce mailer as one two-sided page by photocopying the second page on the reverse side of the first. This mailer may be reproduced on agency letterhead.

• Certificate of Completion (1 page)	• 1 per participant

Instructor's Time Table and Notes

MITCH Module Title: _____

Training Location _____

Date_____

Instructor _____

Preparation

Date	Task	Completed
_____	Review module	_____
_____	Preview videotape* and audiotape	_____
_____	Arrange for guest speaker*	_____
_____	Set date	_____
_____	Arrange for room	_____
_____	Arrange for A-V equipment*	_____
_____	Advertise	_____
_____	Photocopy all handouts	_____
_____	Prepare any overheads	_____
_____	Collect additional materials	_____

Notes for Training
Hour 1:

Hour 2:

*** if applicable**

Trainer's Time Table and Notes, continued
Hour 3:

Six-Week Follow-Up Activity

Date	Task	Completed
_____	Copy letters	_____
_____	Send letters	_____
_____	Collect activity	_____
_____	Review activity	_____
_____	Copy certificate	_____
_____	Prepare certificate	_____
_____	Deliver certificate	_____
_____	Record trainees who have completed module	_____
_____	Maintain List of Participants on file	_____

Notes:

Coming . . . MITCH Module 13

Interventions for Children At Risk Due to Substance Abuse: Dealing with the Myth of Cocaine

TRAINING FOR CAREGIVERS OF INFANTS AND TODDLERS

Date ..... **Time** .....

Location .....

Training Agency .....

For information and/or registration, call .....

.....

.....

Coming . . . MITCH Module 13

Interventions for Children At Risk Due to Substance Abuse: Dealing with the Myth of Cocaine

TRAINING FOR CAREGIVERS OF INFANTS AND TODDLERS

Date ..... Time .....

Location .....

Training Agency .....

For information and/or registration, call .....

.....

.....

LIST OF PARTICIPANTS

SIGN IN SHEET
MITCH Module # _____ _____

MITCH module title _____

Training date _____

Training location _____

Instructor _____

Hours Attended			
1st	2nd	3rd	*FA

Please PRINT your name, social security number, home mailing address, phone and place of work.

Full Name _____ Social Security _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Place of Work _____

Work Address _____ Zip _____

Full Name _____ Social Security _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Place of Work _____

Work Address _____ Zip _____

Full Name _____ Social Security _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Place of Work _____

Work Address _____ Zip _____

Full Name _____ Social Security _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Place of Work _____

Work Address _____ Zip _____

*** Follow-Up Activity completed**

Dear

This is to remind you that the Six-Week Follow-Up Activity for MITCH Training Module # _____

Title: _____

is due _____/ _____/ _____.

Please submit your Follow-Up Activity to:

_____

_____

_____

_____

If you have any questions, please call:

_____ *telephone* _____.

Sincerely,

Staple

Fold #2

From: MITCH Module Training

To:

Fold #1

Certificate of Completion

MITCH

Model of Interdisciplinary Training for Children with Handicaps

_____

has completed all requirements for MITCH Module 13, entitled:

INTERVENTIONS FOR CHILDREN AT RISK DUE TO SUBSTANCE EXPOSURE: DEALING WITH THE MYTH OF COCAINE

_____
Instructor

_____
Training Agency

_____
Date

This training module was developed by the MITCH Project, the Florida Diagnostic and Learning Resources System/South Associate Center, and the Bureau of Education for Exceptional Students, Florida Department of Education.

Appendix B

Reproducible Copies of Handouts/Overheads/Booklets

Note:

Each handout is numbered in a three-digit code such as: Handout 3-1-4. The first digit (3 in example) refers to the module number. The second digit (1 in example) refers to the hour of the Module, while the last number (4 in example) refers to the number of the handout itself. Consequently, the example number above denotes the fourth handout to be used during the first hour of Module 3.

Definition of Terms

Attachment: an affectionate bond between two individuals that joins them emotionally (Kennell)

Bonding: the process by which an infant develops trust and attachment to a consistent caregiver; is essential for healthy psychological development (*Cocaine Babies*)

Congenital: existing at or since birth

Gestation: carrying a child in the uterus; pregnancy

Intervention: the act of coming between two things; to prevent or alter a condition

Pediatrician: a doctor that specializes in development, care, and diseases of children

Perinatal: occurring at or about the time of birth

Placenta: the organ that connects the unborn baby to the mother's uterus and controls the amount of food and oxygen the unborn baby receives

Postnatal: occurring after birth

Prenatal: occurring before birth

Primary caregiver: the most important person during the growth and development of an infant or toddler

Uterine lining: the inner surface of the uterus

Womb: the uterus

COCAINE

- is a quick to act, powerful stimulant
- comes from the coca bush
- is known as "coke," "rocks," "snow, "blow," or "toot"
- is a powder often combined with other substances (talcum powder, flour, laxatives, sugar, or local anesthetics)
- is ingested by inhaling ("snorting"), injecting, or smoking
- is used by persons of all races and economic status
- is ILLEGAL

CRACK

- is a nearly pure form of cocaine
- is a light brown or milky white pellet or "rock"
- is smoked
- is fast acting (affects the brain within 15 seconds)
- causes a dramatic "high"
- makes user feel powerful and sexually aroused
- has a short-lived effect
- leaves user feeling depressed, paranoid, and irritable very quickly
- addicts users in as few as two to three weeks

POSSIBLE Effects of Cocaine Use During Pregnancy

- A higher risk of miscarriage in first three months.

- During the last three months there can be:
  - increased fetal movement
  - a breaking away from the womb by the placenta
  - increased blood pressure and heart rate in the baby.

- An increased risk of premature labor and delivery.

Module	Hour	Handout
13	1	3

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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Use of Cocaine MAY Result in the Following Clinical Signs in the Child

- low birth weight
- rapid respiration and heart rate
- poor feeding patterns
- poor sleeping patterns
- poor state control
- poor visual and auditory attention
- hypersensitivity or irritability
- difficulty in comforting self and being comforted
- depressed interactive abilities
- decreased quality of movement
- increased muscle tone and stiffness

Module	Hour	Handout
13	1	4

Florida Department of Education
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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Cocaine-Exposed Infants May Display Behaviors Similar To Those of Premature Infants, Whether Or Not The Cocaine-Exposed Infants Were Premature

- low birth weight
  - small head circumference
  - shorter stature
- rapid respiration and heart rate
- poor feeding patterns
  - difficulty sucking and swallowing
  - frequent spitting up
  - increased risk for failure to thrive
- poor sleeping patterns
  - difficult to wake up or hypersensitive
  - difficulty sleeping through the night
  - irregular sleeping patterns
- poor state control
  - decreased length of calm state
  - startles frequently
- poor visual and auditory attention
  - poor eye contact
  - frequent gaze aversion
  - poor visual scanning
- hypersensitivity or irritability
  - high-pitched, excessive crying
  - increased sensitivity to environmental stimuli, e.g., noise, lights, handling
- difficulty in comforting self and in being comforted
- depressed interactive abilities
  - decreased smiling
  - decreased vocal sounds and gesturing
- decreased quality of movement
  - poor eye/hand coordination
  - delayed motor development
- increased muscle tone and stiffness
  - tremors
  - increased arching
  - jitteriness

STATES OF NEWBORN BEHAVIOR

Sleep States

Deep Sleep (State 1)

Light Sleep (State 2)

Awake States

Drowsy Sleep (State 3)

Alert (State 4)

Considerable Motor Activity (State 5)

Crying (State 6)

Module	Hour	Handout
13	2	1

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SIGNS OF FATIGUE IN HIGH-RISK INFANTS

Body tone in arms and legs may decrease.

Jaw may drop open.

Cheeks may sag or droop.

Breathing rate may increase.

Infant may yawn.

Eyelids may close.

Module	Hour	Handout
13	2	2

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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

How Caregivers Can Help

Infant Behaviors	What You Can Do
Inability to sleep or irregular sleeping pattern Prolonged and/or high-pitched crying Difficult to comfort	Darken room. Keep the noise level low (turn down radios, telephones, TV). Keep baby's bed away from noisy areas. Give baby a pacifier. Avoid bouncing or jiggling infant before bedtime. Speak in a soft voice. Play soft, "soothing" music or hum. Rock baby gently in a horizontal motion. Swaddle baby gently in a soft blanket with arms crossed on chest and legs flexed. Allow baby's hands to be free. Avoid waking up sleeping baby unless for feeding. Give baby a warm bath (unless baby dislikes water). Take baby for stroller ride or car ride.
Stiffness or rigidness of arms and legs Increased tone Arching of back	Bathe baby in warm water unless baby dislikes water. Use calming techniques. Position baby on its side with knees flexed, back supported. Carry baby in flexed position (knees bent, back supported). Use slow, gentle movements in handling baby. Discourage supported standing. Avoid use of jumpers and walkers.
Frantic sucking of fists	Use baby shirts with sewn-in mitts to prevent skin damage. Use a pacifier. Keep baby's fingernails trimmed short. Feed baby when hungry. Avoid abdominal discomfort by feeding baby slowly, burping baby frequently and completely. Do not allow infant to "gulp" formula or food.
Hyperirritability Hyperactivity Trembling/shaking	Swaddle baby gently but firmly in a soft blanket, with legs flexed. Handle baby gently and slowly. Position baby on tummy or side. Use unstarched, soft blankets/sheets to cover the bed. Hold baby close to your body or use a front pack to secure baby close to you. Use a pacifier.

Module	Hour	Handout
13	2	3

Florida Department of Education
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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

How Caregivers Can Help

Infant Behaviors	What You Can Do
(continued)	Rock baby gently and rhythmically in a vertical motion (vertical rocking).
Hyperirritability	Stroke the infant gently but firmly without talking.
Hyperactivity	Change baby's position frequently (every half-hour to every hour).
	Take the baby for a stroller ride or car ride.
Trembling/Shaking	Speak in a soft soothing voice.
	Decrease environmental stimulation (lights, sounds).
	Give baby a warm bath (unless baby dislikes water).
	Offer frequent small feedings.
	Use four fluid ounce bottles with soft nipples.
Poor Feeding	Feed baby in a quiet, dimly lit room.
	Feed baby slowly and burp frequently, gently, and well.
Spitting Up	Hold baby while feeding; never prop the bottle.
	Support baby's head and neck with your hand or arm.
Vomiting	Hold bottle upright to avoid air bubbles.
	Keep baby lying on side, stomach, or in upright position
Poor Sucking	after feeding to prevent choking.
	Never place baby on back after feeding.
	Wipe off vomited formula immediately with mild soap and water to prevent skin irritation.
	Support chin and both cheeks when feeding to increase sucking ability.
Avoidance of eye contact	Hold baby frequently and securely.
	Rock gently using a slow rhythmical movement.
Difficulty in focusing	Hold baby in upright position facing outward from your body and rock up and down (vertical rock).
Decreased interaction behaviors	Hold high-contrast objects with large designs about 10-12" from baby's eyes.
	Provide interesting stimulation when baby is quiet and alert.
Difficulty establishing a relationship with caregiver	Allow baby to take a time-out as needed.
	Use a steady, even tone of voice.
	Establish routines.
	Do things gradually.
	Use firm pressure when holding infant.

Module	Hour	Handout
13	2	3 (con't.)

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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Swaddled Rocking

Module	Hour	Handout
13	2	4

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Side Lying

Module	Hour	Handout
13	2	5

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Vertical Rocking

Module	Hour	Handout
13	2	6

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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Caregiver Intervention to Aid Sensory Integration

BABY'S STATE	BEGIN WITH
Quiet and alert	Visual stimulation - sight
Active and alert	Tactile stimulation - touch
Drowsy	Auditory stimulation - hearing

VISUAL (Seeing) - Pertaining to the sense of sight

- Initiate eye-to-eye contact slowly.
- Alternate holding object still and moving it across the infant's visual field.
- Present mobiles to the infant.
- Place large, glossy black-and-white photos of family members around the crib.
- Show an object (e.g. six-inch brightly colored ball) to infant.

TACTILE (Touching) - Pertaining to the sense of touch

- Provide slow (12 strokes/minute) hand-to-skin stroking in a head-to-toe direction.
- Stroke with different materials (sheepskin, deep pile velvet).

AUDITORY (Hearing) - Pertaining to the sense of hearing

- Speak slowly (fewer than 50 words/minute).
- Call infant by name at each interaction.
- Play audiotape of parents' voices for 2-3 minutes during alert inactivity.
- Play appropriate (soothing, gentle, simple) music (music box or recording).
- Speak with various inflections; alternate adult speech with baby sounds.
- Talk/sing to infant during feeding, diapering, and play time.

Module	Hour	Handout
13	2	7

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*MITCH: Model of Interdisciplinary Training for Children with Handicaps

Caregiver Intervention to Aid Sensory Integration

VESTIBULAR (Balance) - Pertaining to balance and where we are in relation to gravity and space

- Slowly rock baby in chair, front-to-back.
- Lift infant's head to upright position, tip to right and then to left, stopping at midline.
- Close infant's fist around a small toy (rattle, cloth block).
- Give passive exercise to knee and hip by alternately flexing and extending hip and knee.
- Place infant on a waterbed and slowly move mattress.

OLFACTORY (Smelling) - Pertaining to the sense of smell

- Carry infant to kitchen when cooking smells are present.
- Take infant into fresh air.

GUSTATORY (Taste) - Pertaining to the sense of taste

- Introduce new foods/tastes slowly (not more than one every 3-4 days).

Module	Hour	Handout
13	2	7 (con't.)

Promoting A Healthy Environment Through Nurturing

A child who has not developed a secure attachment to a caregiver may:

- not use adults for play, nurturing, and learning
- have difficulty making choices
- have difficulty reading social cues
- be hard to comfort
- have poor use of eye contact to begin or continue social interaction
- show poor use of gestures to begin social interaction
- show little or no anxiety with strangers or when separating
- indiscriminately attach to new people
- be aggressive with peers or adults
- not follow verbal direction
- not respond to verbal praise
- show delay in imitation, language, and pretend play.

Promoting A Healthy Environment Through Nurturing

Ways Caregivers Can Help

- Provide opportunities for physical contact, mutual touching, and smiling, throughout the day.
- Respond to specific needs of the child on a predictable and regular basis.
- Address the child by name.
- Get eye contact and/or touch the child before giving a verbal command.
- Maintain a setting where the number of adults to children can promote attachment, predictability, nurturing, and on-going assistance in learning.
- Model and provide examples of appropriate coping styles.
- Use caregivers who can tolerate both positive and negative experiences with children.
- Model the expression of feelings.
- Allow the expression of feelings to develop "family closeness" rituals (e.g., hugs, winks).
- Develop hello and goodbye rituals.
- Use security objects (e.g., favorite blanket or toy).
- Encourage structured decision making (e.g., offer a choice between two objects or activities).

Promoting A Healthy Environment Through Structure and Organization

A child whose environment lacks organization may:

- show difficulty handling changes in routine
- display uneven mastery of skills
- be easily overstimulated
- have limited attention/concentration
- show a high activity level
- lack ability to organize tasks
- display difficulty with processing visual and auditory stimulation
- be distracted by extraneous sounds and movements
- display poor problem solving skills and be quick to give up
- not have regular rest patterns
- not know when a task is completed
- be easily frustrated and become irritable in problem solving situations
- not learn incidentally.

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Promoting A Healthy Environment Through Structure and Organization

Ways caregivers can help

- Provide "rituals" of daily living such as sitting at table in a group for lunch.
- Prepare child for changes in routine by cueing (e.g., music/lights on and off).
- Set "gentle but firm" limits on harmful behavior.
- Make expectations of behavior clear.
- Match expectations with child's level of emotional maturity.
- Support child in difficult tasks.
- Model appropriate play.
- Model how to solve conflicts.
- Help child recover from stressful situations with patience, comfort, and understanding.
- Provide "verbal" cues for tasks and problem solving.
- Keep a calm environment to avoid overstimulation.
- Model appropriate ways to display excitement and other emotions.
- Reduce interruptions of routine as much as possible.
- Limit number of objects in the room.
- Establish routines with a minimum number of transitions.
- Direct child to watch another child who is using a successful strategy.
- Recognize and consistently praise child's attempts and accomplishments.
- Ask older child to verbalize steps of a task as task is performed.
- Talk the child through task if child is unable to verbally give steps of task.
- Provide the child with an opportunity to take turns with peers and adults.
- Routinely alert the children one-two minutes before an activity ends.

Promoting A Healthy Environment Through Play

A child who has difficulty with play may:

- not be able to organize play, select materials, or focus adaptively
- have poor peer relationships
- be unable to take turns
- show limited pretend play
- respond impulsively before "reflecting"
- easily "give up" without trying other strategies
- make little use of trial and error strategies
- show little spontaneous play with increased aimless wandering
- have difficulty applying acquired skills to play
- be easily overstimulated by too many things and people, and too much light and noise
- not focus on tasks in play or work situation
- not initiate interactive play
- not progress from parallel to interactive play.

Module	Hour	Handout
13	3	3

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Promoting A Healthy Environment Through Play

Ways caregivers can help

- Respond to and follow the child's lead in play.
- Model play and toy choices for child with correct verbal cues.
- Provide child with opportunities to take turns with peers and adults.
- Model interactive play, providing child with support and encouragement during play.
- Initiate and model dramatic or representational play with child.
- When child initiates dramatic play respond to child with verbal responses or by playing with the child.
- Recognize the importance of children making decisions for themselves and provide many opportunities to do so.
- Sometimes provide child with toys and/or small areas in the classroom that are the child's alone, and do not have to be shared.
- Find out what is available for the child in the child's home and make matches to objects at center.
- Regulate the number of toys to provide enough but not too many as to overstimulate the child.

Module	Hour	Handout
13	3	3 (con't.)

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Promoting A Healthy Environment Through Behavior Management

A child who displays unpredictable behavior may:

- exhibit behavioral extremes
- test limits
- display impulsive behavior
- be irritable much of the time
- display unusually strong emotional responses
- lack goal-directed behavior
- be under-reactive, lethargic, withdrawn
- display little appropriate laughter
- have difficulty with transitions and changes
- have difficulty controlling own behavior
- refuse to comply with simple commands
- not respond to verbal praise from adult
- ignore limit setting
- appear clinically depressed
- be shunned by peers
- not learn social rules
- receive negative responses from adults.

Module	Hour	Handout
13	3	4

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Promoting A Healthy Environment Through Behavior Management

Ways caregivers can help

- Provide the child with explicitly consistent limits of behavior.
- Take every opportunity to develop close caregiver-child relations.
- Keep the child close to adult and supply cues for appropriate behavior.
- Help the child to read caregiver cues by explaining to the child what the caregiver's look, body language, or gesture means.
- Allow, identify, and react to child's expression of emotions:

pleasure	protest	excitement
anger	self-assertion	curiosity
dependency	love	fear.

- Use books, pictures, dolls, and conversation to explore and help child to express a range of feelings.
- Model appropriate expression of the full range of emotions for the child.
- Model other behavior that is appropriate for children to imitate.
- Be respectful of children's work and play space.
- Know that feelings are real, important, and legitimate; children behave and misbehave for a reason, even if it is not apparent.
- Talk about behavior and feelings with empathy rather than judgement. This validates the child's experiences and sets up an accepting atmosphere.
- Talk the older child through to consequence of child's action.
- Remember, until children experience having their own needs repeatedly and consistently met, they will not become aware of the needs and feelings of others.

Module	Hour	Handout
13	3	4 (con't.)

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Promoting A Healthy Environment Through Language

A child with delayed language may:

- have difficulty in recalling words
- have inappropriate use of words/gestures to communicate wants and needs
- display the articulation of a younger child
- have difficulty in understanding what is said
- be unable to follow directions
- be unable to communicate simple wants and needs, express feelings, or describe experiences and events effectively
- be an "observer" rather than verbally engage with peers in play
- initiate inappropriate interaction with peers by hitting, pushing, biting, swearing, or using negative verbal commands
- have learning problems.

Promoting A Healthy Environment Through Language

Ways caregivers can help

- Create a stable environment where the child feels safe to express feelings, wants, and needs.
- Use "hands-on" activities to reinforce the child's language.
- Give simple one-step directions and increase the number of steps in a direction over a long period of time.
- Use eye contact.
- Provide names of people, pets, food items, body parts, objects, feelings, and events in the process of conversation.
- Use language in the context of an activity.
- Respond immediately to beginning attempts at verbal communication.
- Investigate child's behavior by asking child structured or choice questions, to discover what the child needs, wants or fears. Avoid open-ended or high order questions such as "why?"
- Acknowledge and verbalize the needs, wants, and fears the child may have.
- Provide alternative strategies (e.g., pointing, pictures) for the child to appropriately express needs, wants, or fears..
- Recognize that negative behavior may be a signal of child's unmet needs.
- Reflect the child's feelings.
- Verbally cue child's attempts toward adaptive behavior.
- Model and provide child with verbal language to use with other children.

Module	Hour	Handout
13	3	5 (con't.)

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Promoting A Healthy Environment Through Stress Management

A child who is under stress may:

- daydream much of the time
- have a grave, solemn face; rarely smile or laugh
- display frequent prolonged temper tantrums
- cry a great deal
- be unconsolable for months after entry into group care
- act sullen, defiant
- punish self through slapping, head banging, or calling self names ("bad boy")
- be overly sensitive to mild criticism
- flinch if adult approaches with caressing or reassuring gesture
- report proudly to caregiver that he or she has hurt another child
- be highly demanding of adults even though self-sufficient
- carry out repetitive, stereotyped play that may have destructive aspects
- cling to or shadow caregiver although in group for months
- have constant need to sleep although physically well
- be preoccupied with images of monsters or other threatening figures
- be very active or restless; wander around, disturb toys and games
- be unable to settle into constructive play
- display disturbed bodily functions (trouble with feeding, constipation, or diarrhea, soil self frequently months after toilet training)
- display trembling of hands or facial twitches although apparently well
- compulsively talk about physical dangers and threats
- display reduced attentional capacity
- stimulate self by prolonged thumb-sucking, masturbating, or rocking
- stutter, use disfluent speech, or refuse to talk in group
- be clumsy with simple manual tasks due to muscular tensions.

Promoting A Healthy Environment Through Stress Management

Ways caregivers can help

- Recognize when a child is stressed. Be alert to changes in behavior.
- Enhance children's self-esteem wherever and whenever possible through encouragement, caring, focused attention, and warm personal regard. You are the mirror that reflects the personal worth of each child.
- Encourage each child to develop a special interest or skill that can serve as an inner source of pride and self-esteem.
- Provide a quiet, calm atmosphere.
- Anticipate and avoid stressful occasions.
- Give back and neck rubs with firm, long strokes.
- Acknowledge children's feelings and encourage talking about fears and concerns. Help children learn that they are not alone in having uncomfortable feelings. Give them permission to feel scared, lonely, or angry.
- Help them see how others feel upset if their play or rights are interfered with.
- Give children words to express their negative feelings so that they will not have to be aggressive or disorganized when stressed. "I" statements help a child communicate personal upset and strong wishes rather than accusing, hurting, or threatening others.

Promoting A Healthy Environment Through Movement

A child with poor motor skills may:

- have difficulty with motor coordination
- have poor visual perceptual skills
- display tremors when reaching
- trip or stumble without apparent cause
- have difficulty with gross motor skills (swinging, climbing, throwing, catching, jumping, running, and balancing)
- walk into stationary or moving objects
- show splaying of fingers, immature grasping skills
- have difficulty manipulating objects (stacking, stringing, cutting, drawing).

Promoting A Healthy Environment Through Movement

Ways caregivers can help

- Guide child through motor activites that emphasize rhythm, balance, and coordination.
- Model and guide child in learning to control child's body through songs, games, and play.
- Provide child with opportunities to experience spatial relationships with walk- or crawl-through mazes, outdoor play, and indoor play.
- Provide a large variety of objects for tactile and small motor activities (water and sand play, pegboards, puzzles, blocks).
- Observe child and note tremor occurrences and duration, and how child compensates for tremors. Physician may need to be consulted and physical or occupational therapy may be indicated.
- Keep space uncluttered.
- Provide verbal cues.

Appendix C

Reproducible Forms for the Six-Week Follow-Up Activity

The Six Week Follow-Up Activity

MITCH Module 13

CHILDREN OF SUBSTANCE ABUSING PARENTS:

What You Need to Know

These completed forms should be sent to:

Name _____

Address _____

These forms are due at the above address by _____
date

DIRECTIONS:

Please answer the following questions. If you do not have a substance-exposed child in your care, skip question one (1).

Name _____

Date _____ _____

MITCH Module 13

1. *Since participating in the training, have you provided care or services to a child identified as being substance-exposed?*

   _____Yes _____No

2. *Has training been helpful to you in meeting the individual needs of child?*

   _____Yes _____No

   Please list three things you will do differently to meet the individual needs of children:

   a._____

   b._____

   c._____

3. *Did training help you to develop a different attitude toward working with substance-exposed children?*

   _____Yes _____No

4. *List three changes you have made in your caregiving program as a result of the training. Please describe.*

   a._____

   b._____

   c._____

5. *Do you think your role in working with these children and their parents has changed since taking the training?*

   _____Yes _____No

   *Please describe.*_____

   _____

   _____

6. *What other questions do you have about working with substance-exposed children?*

_____

_____

_____

7. *Make a list of support services/resources available within your community for persons working with substance exposed children.*

Agency Name:_____

Address:_____

_____

Phone: (____) _____

Agency Name:_____

Address:_____

_____

Phone: (____) _____

Agency Name:_____

Address:_____

_____

Phone: (____) _____

Agency Name:_____

Address:_____

_____

Phone: (____) _____

Interventions for Children At Risk Due to Substance Exposure: Dealing with the Myth of Cocaine

For ease of use, instructor is encouraged to remove the staple on this booklet and place the module into a three-ring binder.

Trim the binder identifier to an appropriate size, and affix to the spine of the binder.

BINDER IDENTIFIER

BEST COPY AVAILABLE

State of Florida
Department of Education
Tallahassee, Florida
Betty Castor, Commissioner
Affirmative action/equal opportunity employer

BEST COPY AVAILABLE